Division of Health Care Facilities PRINTED: 02/04/2016 STATEMENT OF DEPIGIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CUA AND PLAN OF CORRECTION (X2) MULYIPLE CONSTRUCTION DENTIFICATION NUMBER: A BUILDING: 01 - MAIN BUILDING 01 (X3) DATE BURVEY COMPLETED TN1301 NAME OF PROVIDER OR SUPPLIER 02/01/2016 STREET ADDRESS, CITY, STATE, 2IP CODE CLAIBORNE COUNTY NURSING HOME 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) IO PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LOC IDENTIFYING INFORMATION) TAG (XS) COMPLETE DATE EAT DEFICIENCY 1200-8-6-.08 (5) Building Standards N 835 N 835 N 835 (5) No new nursing home shall be constructed, nor shall major alterations be made to an existing With the current Wanderguard nursing home without prior written approval of the department, and unless in accordance with plans Resident Safety System we have and apecifications approved in advance by the an emergency escape plan with department. Before any new nursing home is the following interventions: (1) a licensed or before any alteration or expension of a licensed nursing home can be approved, the staff member cuts the applicant must furnish two (2) complete sets of Wanderguard bracelet from the plans and specifications to the department, resident or the staff member together with fees and other information as required. Plans and specifications for new presses 2 keys on an existing construction and major renovations, other than keypad mounted at the door to minor alterations not affecting fire and life safety prevent impeded or functional issues, shall be prepared by or under the direction of a licensed architect and/or escape/entrapment. The facility a licensed engineer and in accordance with the elects to upgrade and install a rules of the Board of Architectural and delayed egress and panic devides Engineering Exeminers. system and have received quotes for an acceptable system. Corporate licensed architects This Rule is not met as evidenced by: and/or licensed engineers are in Based on observation, Interview, and record the process of preparing plans review, the facility failed to ensure alterations to and specifications for installation the facility were made wilhout prior approval from of the replacement system in the Department of Health. accordance with the rules of the The finding includes: Board of Architectural and Observation and interview with the maintenance Engineering Examiners for director on 2/1/18 at 10:00 AM revealed the submission to the State for facility had in place a wanderguard system on exit review and acceptance. doore that had not been submitted and approved A letter requesting a waiver for by TOOH, continued temporary use of the This finding was verified by the maintenance current Wanderguard Resident director and acknowledged by the administrator Safety System until the new Division of Health Care Facilities magnetic locking hardware LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM ニヘリナイラ

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NAME OF	OPD/89-5	TW1301	B. WING	· ·	}		
NAME OF PROVIDER OR SUPPLIER STREET AN			DORESS, CITY, STATE, ZIP CODE			1/2018	
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J	not shall read the 100	nome shall be constructed,	[ ]	•			
. ]				system is submitted th		rough the	
					system is submitted through the		
			· 1	proper channels; approved by the			
				appropriate State entity is being			
			-	submitted to Mr. N			
		y alteration or expansion of the	}	Rodriguez, State of Tennessee			
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			ļ	Fire Safety Supervisor. Once			
			1	approval from Plans Review is			
ء ا	equired. Plans and s	Pecilications for new		received, installation of the new			
			į.	system will be completed within			
			1	6 (six) weeks. We seek this			
	or functional issues, shall be prepared by or under the direction of a licensed exchitect and/or a licensed exchitect and/or			waiver in the interest of our			
	a licensed engineer and in accordance with the rules of the Board of Architectural and			Resident's who wander and are			
			ſ	on the second floor with door			
] ~	ngineering Examiner	8.	ł				
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				Responsible Perso	n: Fadilit	ru J	
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B	his Rule is not met a:	s evidenced by:			كالمريية	1	
16,	VIEW the feetings	Interview, and record	ł	Completion Date:	<i>3/4/</i> 2016	tor	
			l	Architectural/Engi	ncering n	lans	
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1:"	e Department of Heal	iin.					
ľΥh	e finding includes:	. , , . ]	1	Tennessee, Install			
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TSi	a finding was		- 1	of receipt of State	approval	.	
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Division of Health Care Facilities FORM APPROVED							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING: 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
<u></u> .	TN1301		B. WING		02/01/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, (	STATE, ZIP CODE			
CLAIBO	RNE COUNTY NURSI		KNOXVILLI LL, TN 3787				
(X4) ID PREFIX TAG				(X5) COMPLETE DATE			
N 835	Continued From page 1		N 835	-		<u>'</u>	
	during the exit confe	erence on 2/1/16.					
	(18) It shall be demi submission of plans each nursing home be maintained in the room, janitor's clossuch soiled spaces, shall be maintained but not limited to, cliutility rooms.  This Rule is not me Based on observation and interest findings include Observation and interest or on 2/1/16 be PM revealed the folloprovided with required.  Janitor's closet, C. Hopper/bio-hazafloors.  Second floor jan These findings were	his Rule is not met as evidenced by: ased on observation and interview, the facility alled to ensure all areas required were provided ith negative air pressure.  the findings include: bservation and interview with the maintenance rector on 2/1/16 between 11:20 AM and 1:29 M revealed the following areas were not rovided with required negative air pressure;  Janitor's closet, B hall, first floor. Hopper/bio-hazard room on first and second pors. Second floor janitor's closet.		N 848  To resolve this deficiency. Nursing Home Housekeep Staff will be trained by maintenance on how to chand log negative airflow. negative pressure airflow check and documented in daily by housekeeping in to following areas: (1) the N Janitor's closet, B hall, fire (2) Hopper/bio-hazard roofirst and second floors and second floor janitor's close ensuring that negative presmaintained consistently. Maintenance department personnel will conduct we checks to verify process. Responsible Person: Facil Safety Manager  Completion Date: Applicated the process of the educated by 2/26/2016. Daily / weekly and documentation of results.	eck Daily will be the log he H st floor, m on (3) et, essure is ekly ity ble checks		
	These findings were	Verified by the maintenance edged by the administrator		2/26/2016. Daily / weekly	checks alts are		

<u>Division</u>	n of Health Care Fac	llities		•	FORM	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING: 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
		TN1301	B. WING	_ <del></del>	02/0	1/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, 8	STATE, ZIP CODE			
CLAIBORNE COUNTY NURSING HOME 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)			
N 835	Continued From pa during the exit confi		N 835	N 848 Continued			
	submission of plans each nursing home be maintained in the room, janker's clossuch soiled spaces, shall be maintained but not limited to, of utility rooms.  This Rule is not me Based on observatifailed to ensure all a with negative air pretained to ensure all a with negative air pretained to ensure all a with negative air pretained to ensure all a with negative air pretained. Discretion and interior on 2/1/16 be PM revealed the followed with required.  Janitor's closet; Hopper/blo-hazafloors, Second floor janthese findings were	onstrated through the and specifications that in a negative air pressure shall a soiled utility area, tollet set, dishwashing and other and a positive air pressure in all clean areas including, ean linen rooms and clean set as evidenced by: on and interview, the facility areas required were provided essure.  The erview with the maintenance etween 11:20 AM and 1:29 owing areas were not ed negative air pressure;  B hall, first floor.  Brd room on first and second allor's closet.  Verified by the maintenance ledged by the administrator	N 848 Continued  To ensure that negative press in these areas is maintained, airflow verification will be a to the monthly Environment  Care Safety Round sheets als Compliance rate of log/cheel completion and negative air status will be reported month the NH Administrator, organizations Senior Leaders Team and to each scheduled Environment of Care Command Quality Management meetings by the Facility Safe Manager		ed, ne added ent of s also, neck air flow onthly to dership led mmittee		
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